July 1, 2006 – June 30, 2007

Benefit	Maryland Point of Service	
	In-Network	**Out-Of-Network**
Deductible	None	$500 Individual/$1,500 Family
Out-of-Pocket Maximum	None	$2,000 Individual/$4,000 Family
PHYSICIAN SERVICES		
Surgeon	100% AB	80% AB after deductible
In-Hospital	100% AB	80% AB after deductible
HOSPITAL		
Hospital Room/Semi Private*	100% AB	80% AB after deductible
Outpatient Surgery**	100% AB	80% AB after deductible
Emergency Care (within 72 hours) • Facility • Facility/Practitioner • Provider's Office	 100% AB 100% AB 100% AB	 100% AB 100% AB 100% AB
MEDICAL SERVICES		
Diagnostic X-rays	Outpatient/Office 100% AB	Outpatient/Office 100% AB
Radiation & Chemotherapy	100% AB after $25 facility Copay and $15 Professional Copay	80% AB after deductible for professional/$35 facility Copay
Laboratory Tests	Outpatient/Office 100% AB	Outpatient/Office 100% AB
Allergy Testing	100% AB	80% AB after deductible
Allergy Treatment/Injections	100% AB	80% AB after deductible
Physical Therapy	100% AB after $15 Copay 100 visit limit	80% AB after deductible 100 visit limit
PREVENTIVE CARE		
Well Baby & Child Care	100% AB after $15 Copay	80% AB no deductible
Immunization	100% AB	80% AB no deductible
Annual Physical Exam	100% AB after $15 Copay one per calendar year $200 maximum	80% AB after deductible
Annual Gynecological Exam	100% AB after $15 Copay one per calendar year	80% AB after deductible
Eye Exams	No benefit for routine exam	No benefit for routine exam
Eye Glasses	No benefit	No benefit
OFFICE		
Medical Visits for Illnesses	100% AB after $15 Copay	80% AB after deductible
SPECIAL SERVICES		
Hearing aid evaluation test (one every 36 months)	100% AB, no deductible	80% AB after deductible
Hearing aids (one every 36 months)	100% AB, no deductible	80% AB after deductible
Home Health Care Visits	100% AB; approved plan of treatment required	100% AB; approved plan of treatment required
Maternity Care	100% AB	80% AB after deductible
Infertility Services Artificial Insemination & In Vitro Fertilization	Not covered	Not covered
Ambulance (when medically necessary)	100% AB	100% AB
MENTAL HEALTH/SUBSTANCE ABUSE COMBINED		
Inpatient Care*	100% AB (services must be preauthorized)	80% AB after deductible (services must be preauthorized)

	In-Network	Out-Of-Network
Outpatient Care (services must be preauthorized)	Visits 1-5, 80% AB Visits 6-30, 65% AB Visits 31+, 50% AB	Visits 1-5, 80% AB after deductible Visits 6-30, 65% AB after deductible Visits 31+, 50% AB after deductible
PRESCRIPTION DRUG PROGRAM		
	$8 Copay – generic drugs $15 Copay – brand-name preferred drugs $30 Copay – non-preferred drugs Maintenance drugs: Retail – 3 Copays Mail Order – 2 Copays	$8 Copay – generic drugs $15 Copay – brand-name preferred drugs $30 Copay – non-preferred drugs Maintenance drugs: Retail – 3 Copays Mail Order – 2 Copays

This chart contains highlights only and is subject to change. The specific terms of coverage, exclusions and limitations are contained in the Summary Plan Description, the Health Benefits Certificate, the Group Benefit Guide or the Group Service Agreement.

AB-Allowed Benefit.

**Inpatient stays require precertification. ***If the hospital bills for use of the facility or provider bills for use of his office, the member will be subject to the appropriate copays.*